Beth Israel Lahey Health
Lahey Hospital & Medical Center

IV Remdesivir Therapy Referral Form

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____/_____/_____ Patient ZIP code: _____

LHMC Medical Record # _____Preferred Phone: _____

If MRN is not available, the patient will be registered when we call to schedule the appointment.

COVID-19 SYMPTOM ONSET AND DIAGNOSIS: (both must be within 7 days of referral)

Date of Symptom Onset: _____/_____/_____

Date of Positive COVID-19 PCR or Antigen test: _____/_____/_____

COVID-19 Vaccination status: _____ unvaccinated _____ primary series only _____ primary series plus at least 1 booster (if eligible)

CONTRAINDICATIONS TO PAXLOVID:

Please select all reasons why patient is unable to take nirmatrelvir/ritonavir (Paxlovid), which is preferred by state and national guidelines.

- ☐ Drug-drug interactions listed as an absolute contraindication (interacting medication(s): _____)
- ☐ Symptom onset > 5 days
- ☐ Other medical contraindication (please specify: _____)

ADDITIONAL REQUIREMENTS FOR TREATMENT:

☐ Check here to verify that patient has **at least one risk factor** for progression to severe COVID-19

(https://covid-19.bilh.org/wp-content/uploads/bilh-severe-covid-19-risk-factors.pdf)

☐ Check here to verify that patient **does not require oxygen** therapy due to COVID-19 (Including an increase in baseline oxygen flow)

☐ Check here to verify that patient is not known to have renal dysfunction (GFR < 30mL/min) or elevated AST/ALT (> 5x upper limit of normal)

REFERRING PROVIDER INFORMATION:

Provider Name:_____ Provider Institution: _____

Provider Office Number: _____ - _____ - _____

Provider Email: _____

ORDERING PROVIDER AUTHENTICATION:

X _____ _____ ___/___/___ __ __ __ __

Circle: MD NP PA Signature Print Name Date Time (24 hr)

Fax completed referral to: 781-744-3657. Providers may call 781-744-6147 for a scheduling update.